SUMMARY

A case of large, encapsulated renal hemangioma is reported. This is a rare condition which usually is first manifest by hematuria, most often in persons under 40 years of age. Carcinoma of the kidney is the most common preoperative diagnosis and nephrectomy the treatment.

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Aberrant Pancreatic Tissue in the Gastric Wall

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ABERRANT pancreatic tissue has been observed in all portions of the gastrointestinal tract and in adjacent structures.[1, 2, 3] As this ectopic growth is fairly common, it may be suspected in the presence of certain symptoms that cannot be precisely attributed to other pathologic processes in the abdomen. Excellent surveys of the literature have been made by Faust and Mudgett,[3] Barbosa, Dockerty and Waugh,[1] and Busard and Walters.[2]

The review by Busard and Walters summarized 543 cases of ectopic growth of pancreatic tissue. These, plus the case here reported, are summarized in Table 1. The gastric wall is the site of about a quarter, the duodenal wall of another quarter, the jejunal wall of a sixth, and other locations (including 6 per cent in Meckel's diverticula) of a third. While the usual location is submucosal, involvement of the muscularis is common and of the mucosa not rare. The gross lesion is generally a polyp, either sessile or pedunculated, over which there may be a mucosal ulceration. The lesion may be asymptomatic, or it may cause symptoms of peptic ulcer, of hypoglycemia or of neoplastic disease.

TABLE 1.—*Sites of Growth of Aberrant Pancreatic Tissue in 544 Cases*

Location	Number	Per Cent
Wall of stomach	150	27
Wall of duodenum	159	29
Wall of jejunum	85	16
Wall of ileum	32	6
In Meckel's diverticulum	30	6
Wall of gallbladder	15	3
Miscellaneous locations	73	13
Total	544	100

The asymptomatic group is undoubtedly the largest. In many of the reported cases (and no doubt in many not reported) the condition was observed at necropsy as an incidental and unimportant finding. In various autopsy series, the incidence has averaged a little under 2 per cent. In Veterans Administration Hospital, Oakland, only one case (doubtful), other than the one here reported, was observed in 781 routine autopsies. The series reported by Barbosa and co-workers, the largest single group, consisted of 82 patients who were operated upon. In only 39 cases was there believed to be a causal relation between the aberrant pancreatic tissue and the symptoms of which the patient complained. Thus, in 43 of 82 cases in which the condition existed, it caused no symptoms—this in a series of surgical, not autopsy, cases. Of course, when asymptomatic, this condition is unimportant except insofar as it may lead to later complications; and diagnosis could only be reached through some fortuitous circumstance.

Cases in which the aberrant tissue causes an ulcer-like syndrome are perhaps the most perplexing and difficult to deal with from a clinical standpoint, since the symptoms so closely mimic those of peptic ulcer, even to the presence of severe bleeding. In x-ray examination, the secondary signs of duodenal ulcer—spasm, irritability and tenderness of the cap, but without a visible crater—may be observed. In some instances actual mucosal ulceration over the tumor may be present, as has been noted both in operative and in postmortem specimens. More often there is no ulceration. In cases in which the tumor can be observed in gastrointestinal x-ray films the problem is not so difficult of solution, but the tumor is by no means invariably demonstrated. Gastroscopy is not usually helpful, since if the tumor is sessile with intact mucosa it cannot be visualized by gastroscopy, and of course a duodenal tumor is beyond the range of this method. The radiographic appearance is not at all characteristic, since any benign tumor may have the same appearance on a film. In any case in which the symptoms of ulcer are present and there is x-ray evidence of polypoid or sessile tumor in the distal stomach or in the duodenum, with normal mucosa over it and sharp demarcation of the edges, the possibility that the tumor is a pancreatic rest should always be considered.

In cases in which the aberrant growth causes hypoglycemia, an adenoma or adenocarcinoma composed of functioning islet cells leads to hyperinsulinism with the usual clinical symptoms, of which convulsive seizures or episodes of syncope are the most striking. In such cases excision of the tumor is mandatory, and if metastatic lesions are present they should also be removed if at all possible. Tumors of this type are malignant in almost 50 per cent of cases, and later metastasis or recurrence usually causes recurrence of hypoglycemia. It is sometimes very difficult to locate the primary nodule either radiographically or surgically, as it may be anywhere in the abdomen.

Cases in which the tumor is of itself the important factor in the production of symptoms may be divided into two rather distinct subgroups—those in which the growth is malignant, and those in which it is benign. If it is malignant (probably the result of degeneration of an originally benign rest) the symptoms are those of obscure intra-

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abdominal malignant disease; and except that jaundice is not often present, the course is that of pancreatic carcinoma. Although surgical excision is curative if complete, the absence of early symptoms makes it uncommon for the diagnosis to be reached in time. In cases in which the tumor is benign, its presence may be made evident by an episode of obstruction. Rarely are tumors of this order suspected on the basis of roentgenograms. The obstruction may be either partial (as with a tumor encircling the duodenum, the so-called annular pancreas) or complete (as with intussusception). The event may occur either in childhood or in adult life, but in most reported cases of pancreatic rests in children the lesion was discovered as a result of acute intussusception. In any case, the treatment is excision of the rest, with such other procedure as may be indicated.

In the following case, the symptoms were typical of those in which aberrant pancreatic tissue causes symptoms akin to those of ulcer. Although an x-ray diagnosis of duodenal ulcer plus gastric tumor was made, duodenal ulcer was not observed at operation.

REPORT OF A CASE

A 38-year-old fireman had occasional burning pain and heartburn extending up into the throat. These symptoms were first noted about 12 years previously. They occurred possibly two or three times a week up to the time the patient entered the Army. The distress was almost entirely substernal and was usually aggravated by taking coffee, greasy and fried foods, apples and fruit juices. Alka-Seltzer® and bicarbonate of soda almost always gave relief. Usually the distress began about two hours after breakfast, continued through the day, became worse about two hours after the evening meal and continued to become worse until bedtime. Rarely did gastric distress awaken the patient during the night and usually by morning it had abated. Food and milk practically never gave relief, although during the preceding few months on two or three occasions when the patient felt hungry and had some distress in the epigastrium, eating had helped. Bending forward and heavy work were liable to cause heartburn and distress with a bitter or sour taste in the mouth. There was no history of dysphagia, or of nausea or vomiting. The patient said he believed he had not lost weight. Appetite was moderate and no change in it had been noted. There was no history of icterus, melena, hematemesis, acholic stools or dark urine. After the patient was discharged from the Army (some five years before the present examination) epigastric distress was almost continuous. Chronically constipated for about 12 years, the patient often passed hard, lumpy stools. There were no episodes of diarrhea, and blood in the stools had never been noted. On several occasions in the preceding two years the patient had had fleeting and not very severe stabbing or aching pain in the right lower quadrant of the abdomen. The patient was uncertain as to whether these episodes were related to either constipation or substernal distress.

Rhinitis, apparently due to allergic reaction, had been present for several years.

Physical Examination: The patient was well developed and well nourished. There was a mild degree of tenderness in the right lower quadrant of the abdomen on the right side of the midabdomen. No masses were felt and the spleen and liver were not enlarged. There was slight varicocele on the left. In roentgen studies of the gastrointestinal tract, a filling defect 1.5 cm. in diameter in the pyloric region was noted (Figure 1). This appeared to be caused by a gastric polyp. The duodenal bulb was deformed and irregular. The roentgen diagnosis, after three gastrointestinal studies, was polypoid tumor of stomach, and duodenal ulcer, probably active. No abnormalities were noted in the heart and lungs, in a cholecystogram or in barium enema studies. Results of urinalysis were within normal limits. The cell content and sedimentation rate of the blood were normal. Results of

Figure 1.—Preoperative roentgenogram showing polypoid prepyloric tumor and irritability of the cap.

Figure 2.—Postoperative roentgenogram. The irritability of the cap is somewhat increased.

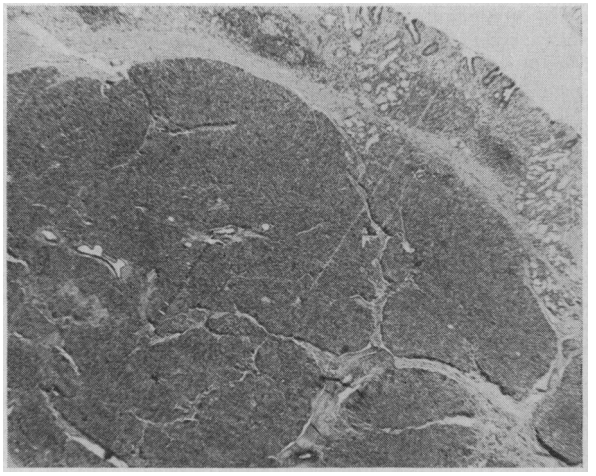

Figure 3.—Low-power photomicrograph of excised tumor.

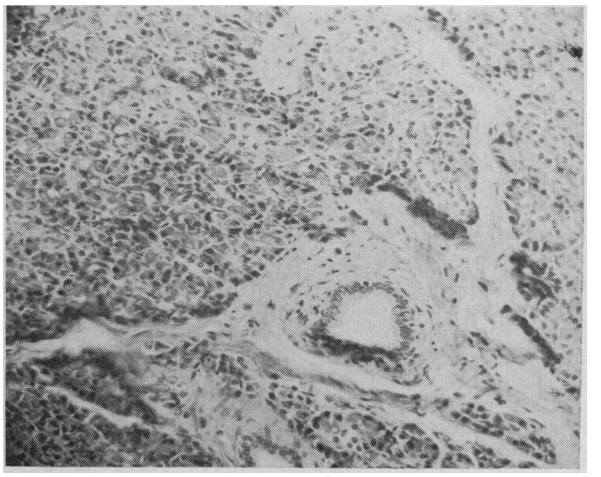

Figure 4.—High-power photomicrograph of excised tumor.

serologic tests were negative for syphilis. In gastric analysis a slight elevation of acidity, both free and total, was noted. The protein (agglutination) ratio was normal. There was a trace of blood in the stool (guaiac test).

The patient was observed in consultation in the allergy clinic and a desensitization program was begun. Gastroscopic examination was carried out on two occasions, but no tumor was visualized. In an exploratory laparotomy a polyp was noted in the lesser curvature in the prepyloric area. It was removed through an incision in the stomach. No evidence of duodenal ulcer was observed. Postoperatively the patient had a severe reaction to a blood transfusion. The pathologist reported the reaction as allergic since there was no evidence of agglutination or hemolysis. Postoperative treatment consisted of bed rest, administration of penicillin, and gradually progressive diet. No tumor tissue was visualized in postoperative x-ray films but there was evidence of continued irritation of the duodenal cap (Figure 2).

Pathologic Report: The specimen was a slightly polypoid mass of soft, rubbery connective tissue, partially covered by an intact, normal appearing mucous membrane. It was 1.2 cm. in length and from 0.6 to 1 cm. in diameter. In the central portion of the mucosa was a small pin-point umbilication. The sectioned surface was made up of a mass of soft, yellow tissue demarcated into small lobules of irregular fine strands of fibrous tissue.

Microscopically observed, the tissue was composed of an irregular, uncircumscribed mass of adult pancreatic tissue embedded within gastric submucosa which was made up predominantly of the exocrine elements with a few scattered abortive islets of Langerhans. Well defined pancreatic ducts, some of them atrophic and others dilated and semicystic, were observed. The glandular lobules were surrounded by fine hyalized fibrous tissue trabeculae. The gastric mucosa was intact but focally thin and atrophic. There were a few chronic inflammatory cells scattered throughout the subepithelial connective tissue, and, focally, pancreatic ductal tissue extended upward into the mucosa itself (Figures 3, 4).

The pathologic diagnosis was aberrant pancreatic tissue in the gastric wall.

SUMMARY

A case in which a pancreatic rest in the stomach caused an ulcer-like syndrome is reported. A roentgen diagnosis of polypoid gastric tumor with secondary signs suggesting duodenal ulcer was surgically verified as regards the tumor but not the ulcer. The case reported is typical of one of the four classifications of cases of aberrant pancreatic tissue. Certain other typical clinical syndromes are reviewed for comparison.

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Rectal Hemorrhage Caused by Injection Slough

A Report of Two Cases

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MANY clinicians have described the occurrence of bleeding as a complication of the injection treatment of hemorrhoids. There may be slight loss of blood at the time of injection, but serious hemorrhage is rare. When it occurs, it usually follows slough which causes erosion of a blood vessel. The rectum and rectosigmoid can retain a considerable amount of blood before the defecation reflex is stimulated, especially if the bleeding begins while the patient is asleep.

The following two cases are of interest because the character and the amount of the bleeding were more typical of polyp or neoplasm than of injection slough. They are presented to reemphasize the occurrence of severe bleeding as a complication of the injection treatment of hemorrhoids.

CASE 1. A 39-year-old white woman was observed in the office following the passage of a large amount of blood from the rectum. Most of the blood was in the form of dark clots, but some of it was bright red and uncoagulated. The patient said that for many years she had been treated for "spastic

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